FY 12 PATH Program
Daily Homeless Outreach Tracking Log

Date	Name of Person Outreached	Location of Outreach Activity	Homeless/ At Risk of Homeless? Yes/No	Suspected Mental Illness? Yes/No	Referred to PATH Case Management? Yes/No

TOTAL Outreach Contacts: _____

**This is a sample collection tool for documentation for PATH funded Outreach

FY 12 PATH Program
Eligibility Screening & Needs Assessment

I. CONTACT INFORMATION

Name: _____DOB_____

SS#: _____Referral Source/Site_____

Current Address/Shelter: _____

_____

Available Transportation/Car: _____

Message phone number: _____

Emergency Contact Person: _____ (Phone)_____

Address: _____

II. DEMOGRAPHIC INFORMATION

Age: _____ Gender: ☐ Male ☐ Female

Race/Ethnicity: ☐ Hispanic/Latino ☐ African American ☐ White
☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ 2 or More Races ☐ Unknown

Veteran Status: ☐ Veteran ☐ Non-Veteran ☐ Unknown

III. HOUSING INFORMATION

☐ Housed (*Not PATH Eligible*) ☐ Homeless ☐ At Risk of Homelessness

Housing Status at First Contact:
☐ Outdoors ☐ Short Term Shelter ☐ Long Term Shelter
☐ Own or someone's Apt/House/Room ☐ Hotel, SRO, Boarding House
☐ Halfway House/Residential Treatment Program ☐ Institution (State Hospital/Prison)
☐ Jail ☐ Other ☐ Unknown

Time Living On Streets upon First Contact:
☐ Less than 2 days ☐ 2days-30 days ☐ 31days-90 days ☐ 91days-1 year
☐ Over 1 year ☐ Unknown

Where you slept last night _____

HOUSING BARRIERS

What keeps you from immediately locating and maintaining stable housing?

_____

IV. MENTAL HEALTH/CO-OCCURRING INFORMATION

Have you ever received Mental Health services: ☐ Yes ☐ No

If Yes, Where: _____

Mental Health Medications: _____

Suspected SMI:
☐ No SMI (*Not PATH Eligible*)
☐ Other Psychotic Disorders
☐ Personality Disorder
☐ MR/DD
☐ Schizophrenia
☐ Affective Disorder
☐ Other SMI
☐ HIV

Substance Abuse:
☐ Co-Occurring SA & SMI ☐ SA Only (*Not PATH Eligible)* ☐ Unknown if SA

PATH Eligibility Criteria:
-homeless or imminent risk of becoming homeless; and
-suspected of having a serious mental illness; and
-not in the custody/guardianship of the State of Georgia; and
-not receiving a similar service in DMHDDAD.

☐ ******Eligible and Enrolled in a PATH Service (date) _____
☐ Eligible but Not Enrolled in PATH
☐ Not Eligible and Not Enrolled in PATH

**Continue ONLY if PATH Eligible and Enrolled in PATH Service

V. MEDICAL INFORMATION

Medical/Dental/Visual Issues: ☐ Yes ☐ No
If Yes,
Please Identify_____

Physical Health Medications _____

Physical Health Physician/Clinic: _____

VI. EMPLOYMENT INFORMATION

Willing and Able to Work: ☐ Yes ☐ No
Currently Employed: ☐ Yes ☐ No
If Able to Work, Why Unemployed: _____

Type of Jobs Interested:_____

VII. INCOME INFORMATION

Earned Income……$_____

Other Assistance…….$_____

Food Stamps……..……..$_____

Financial Resources: **SSDI SSI VA TANF WIC GA** Amount: _____

Medicare # _____ Medicaid #_____

VIII. PATH SERVICE(S) ENROLLMENT:

☐Case Management ☐Housing Service ☐Support & Supervision in Residential Setting

IX. ASSESSED RESOUNCE AND SERVICE NEEDS: (check all that apply)

☐ **Family Reunification**	☐ **Immediate Housing**	☐ **Mental Health Services**
☐ **Drug/Alcohol Services**	☐ **Medical Services**	☐ **Employment**
☐ **Income (SSI/SSDI)**	☐ **Dental Services**	☐ **TANF**
☐ **ID/Birth Certificate**	☐ **Glasses**	☐ **Food Stamps**
☐ **Legal Services**	**Other Needs** _____	

X. ASSESSED READINESS TO CHANGE (check one)

☐ Client Is Not Seriously Considering Change. (Pre-contemplation)
☐ Client Is Seriously Considering Change. (Contemplation)
☐ Client Is Ready to Make a Change. (Preparation)
☐ Client Is Making a Change. (Action)

_____ _____

PATH Staff Signature Date

Sample documentation for client enrollment for any PATH service other than Outreach

PATH Progress Notes

Date	Goal(s) #	Progress Note

**Sample client enrollment documentation for any PATH service other than Outreach.

FY 12 PATH Program Individualized Recovery Plan

Client Name _____

Using Client's Own Words, Identified Long-Term Goal:

Short-Term Goals	Strategies/Interventions	Responsibility Client/Staff	Target Date	Date Accomplished
Goal #1 To Improve Current Housing Condition	1. 2. 3.			
Goal #2 To Access Financial Resources	1. 2. 3.			

Short-Term Goals	**Strategies/Interventions**	**Responsibility Client/Staff**	**Target Date**	**Date Accomplished**
Goal #3 To Access MH/SA Treatment Services	1. 2. 3.			
Goal #4 Other…	1. 2. 3.			

Client Signature: _____Date_____

PATH Member Signature: _____Date: _____

**Sample documentation for client enrollment for any PATH service other than Outreach.

FY 12 PATH Program Discharge Summary

Client Name: _____

Discharge To: _____

Address: _____

Phone: _____

Enrollment Date: _____ **Discharge Date:** _____

Discharged from the following PATH Service(s):
☐ **Case Management** ☐ **Housing Service** ☐ **Support in Residential Setting**

Type of Discharge:
☐ **Low Impact** **(Dropped Out, MIA, Refused Service, Lost Contact)**
☐ **Medium Impact** **(Remains Homeless but Linked to Mental Health Services)**
☐ **High Impact** **(Temporary or Permanent Housed and Linked to Mental Health Services)**

HOUSING STATUS UPON DISCHARGE
1. Homeless:
☐ **Outdoors** ☐ **Abandoned Building** ☐ **Short-Term Shelter** ☐ **unknown**

2. Temporary Housing:
☐ **Long-Term Shelter** ☐ **Homeless Service Center** ☐ **Transitional Housing (up to 24 months)**
☐ **Motel** ☐ **Residential Treatment Program** ☐ **Living with Family/Friends**

3. Permanent Housing
☐ **Supportive Housing Program** ☐ **Shelter + Care** ☐ **Section 8 Voucher** ☐ **Personal Care Home**
☐ **Leases Own apartment/Room/House** ☐ **Other** _____

4. Corrections or Institution
☐ **Jail or Correctional Facility** ☐ **Hospital** ☐ **Nursing Home**

Was Client's Housing Status Improved from Initial Contact to Discharge: ☐ **YES** ☐ **NO**

OBTAINED FOLLOWING SERVICES AND RESOURCES DURING ENROLLMENT:
☐ **Housing (temporary, transitional, permanent)**
☐ **Income Benefits (SSI/SSDI)** ☐ **Georgia ID** ☐ **Self Help (AA, NA, CA DTR)**
☐ **General Assistance Income** ☐ **VA Benefits** ☐ **Employment**
☐ **Primary Health Care** ☐ **Dental Services** ☐ **Food Stamps**
☐ **Mental Health Services** ☐ **Substance Abuse Services** ☐ **TANF**
☐ **Other** _____
NEXT MH/SA Appointment at (agency name)_____ ; on (date/time):_____

DISCHARGE SUMMARY Comments:

_____

_____

PATH Staff: _____ Date: _____